

1 XAVIER BECERRA
Attorney General of California
2 ROBERT MCKIM BELL
Supervising Deputy Attorney General
3 CHRISTINA SEIN GOOT
Deputy Attorney General
4 State Bar No. 229094
California Department of Justice
5 300 South Spring Street, Suite 1702
Los Angeles, California 90013
6 Telephone: (213) 269-6481
Facsimile: (916) 731-2117
7 *Attorneys for Complainant*

8
9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Second Amended
13 Accusation Against:

Case No. 800-2016-024673

14 MAX RUDOLPH LEHFELDT, M.D.

SECOND AMENDED ACCUSATION

15 Post Office Box 1526
South Pasadena, California 91031-1526

16 Physician's and Surgeon's Certificate
17 No. A 80511,

18 Respondent.

19
20 **PARTIES**

21 1. William Prasifka (Complainant) brings this Second Amended Accusation solely in his
22 official capacity as the Executive Director of the Medical Board of California, Department of
23 Consumer Affairs (Board).

24 2. On September 18, 2002, the Board issued Physician's and Surgeon's Certificate
25 Number A 80511 to Max Rudolph Lehfeldt, M.D. (Respondent). That Certificate was in full
26 force and effect at all times relevant to the charges brought herein and will expire on May 31,
27 2022, unless renewed.

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1 **JURISDICTION**

2 3. This Second Amended Accusation is brought before the Board, under the authority of
3 the following laws. All statutory references are to the Business and Professions Code (Code)
4 unless otherwise indicated.

5 4. Section 2227 of the Code provides that a licensee who is found guilty under the
6 Medical Practice Act may have his or her license revoked, suspended for a period not to exceed
7 one year, placed on probation and required to pay the costs of probation monitoring, or such other
8 action taken in relation to discipline as the Board deems proper.

9 5. Section 2234 of the Code states:

10 The board shall take action against any licensee who is charged with
11 unprofessional conduct. In addition to other provisions of this article, unprofessional
conduct includes, but is not limited to, the following:

12 (a) Violating or attempting to violate, directly or indirectly, assisting in or
13 abetting the violation of, or conspiring to violate any provision of this chapter.

14 (b)

15 (c) Repeated negligent acts. To be repeated, there must be two or more
16 negligent acts or omissions. An initial negligent act or omission followed by a
separate and distinct departure from the applicable standard of care shall constitute
repeated negligent acts.

17 (1) An initial negligent diagnosis followed by an act or omission medically
18 appropriate for that negligent diagnosis of the patient shall constitute a single
negligent act.

19 (2) When the standard of care requires a change in the diagnosis, act, or
20 omission that constitutes the negligent act described in paragraph (1), including, but
not limited to, a reevaluation of the diagnosis or a change in treatment, and the
21 licensee's conduct departs from the applicable standard of care, each departure
constitutes a separate and distinct breach of the standard of care.

22 ¶ ¶

23 6. Section 2266 of the Code states: The failure of a physician and surgeon to maintain
24 adequate and accurate records relating to the provision of services to their patients constitutes
25 unprofessional conduct.

26 7. Section 654.2 of the Code states:

27 (a) It is unlawful for any person licensed under this division or under any
28 initiative act referred to in this division to charge, bill, or otherwise solicit payment
from a patient on behalf of, or refer a patient to, an organization in which the licensee,

1 or the licensee's immediate family, has a significant beneficial interest, unless the
2 licensee first discloses in writing to the patient, that there is such an interest and
advises the patient that the patient may choose any organization for the purpose of
obtaining the services ordered or requested by the licensee.

3 (b) The disclosure requirements of subdivision (a) may be met by posting a
4 conspicuous sign in an area which is likely to be seen by all patients who use the
facility or by providing those patients with a written disclosure statement. Where
5 referrals, billings, or other solicitations are between licensees who contract with
multispecialty clinics pursuant to subdivision (l) of Section 1206 of the Health and
6 Safety Code or who conduct their practice as members of the same professional
corporation or partnership, and the services are rendered on the same physical
7 premises, or under the same professional corporation or partnership name, the
requirements of subdivision (a) may be met by posting a conspicuous disclosure
8 statement at a single location which is a common area or registration area or by
providing those patients with a written disclosure statement.

9 ¶ ¶

10 (d) For the purposes of this section, the following terms have the following
11 meanings:

12 (1) "Immediate family" includes the spouse and children of the licensee, the
13 parents of the licensee and licensee's spouse, and the spouses of the children of the
licensee.

14 (2) "Significant beneficial interest" means any financial interest that is equal to
or greater than the lesser of the following:

15 (A) Five percent of the whole.

16 (B) Five thousand dollars (\$5,000).

17 (3) A third-party payer includes any health care service plan, self-insured
18 employee welfare benefit plan, disability insurer, nonprofit hospital service plan, or
private group or indemnification insurance program.

19 A third party payer does not include a prepaid capitated plan licensed under the
20 Knox-Keene Health Care Service Plan Act of 1975 or Chapter 11a (commencing with
Section 11491) of Part 2 of Division 2 of the Insurance Code.

21 ¶ ¶

22 8. California Code of Regulations, title 16, section 1364.11, states:

23 The amount of any fine to be levied by a board official shall take into
24 consideration the factors listed in subdivision (b)(3) of Section 125.9 of the code and
shall be within the range set forth below.

25 (a) In his or her discretion, a board official may issue a citation under Section
26 1364.10 for a violation of the provisions listed in this section.

27 ¶ ¶

28 (10) Business and Professions Code Section 654.2.

¶ ¶

(b) In his or her discretion, a board official may issue a citation under Section 1364.10 to a licensee for a violation of a term or condition contained in the decision placing that licensee on probation.

(c) A citation may include a fine from \$100 to \$2500. However, a citation may include a fine up to \$5,000 if one or more of the following circumstances apply:

(1) The cited person has received two or more prior citations for the same or similar violations;

(2) The citation involves multiple violations that demonstrate a willful disregard for the law.

(d) In his or her discretion, a board official may issue a citation with an order of abatement without levying a fine for the first violation of any provision set forth above.

(e) The sanction authorized under this section shall be separate from and in addition to any other administrative, civil, or criminal remedies.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

9. Respondent's license is subject to disciplinary action under Code sections 2234, subdivisions (a) and (c), in that he committed repeated negligent acts in the care and treatment of three patients. The circumstances are as follows:

10. Respondent is a board-certified plastic surgeon. He practices plastic and reconstructive surgery.

Patient A¹

11. Patient A, a 58-year-old female, had been diagnosed with the BRCA2 gene mutation, which placed her at a higher risk for the development of breast and ovarian cancer. Patient A sought a prophylactic mastectomy from a breast surgeon and breast reconstruction from a plastic surgeon.

12. Prior to seeing Respondent, Patient A had been informed by two plastic surgeons that she would require nipple removal and skin reduction to achieve her goal of smaller, more uplifted reconstructed breasts.

¹ Patients are referred to by letter to protect their identities. The identity of each patient is believed to be known by Respondent. Further information relating to the patients will be provided in response to a request for discovery.

1 13. Patient A was referred to Respondent by the breast surgeon who ultimately performed
2 the prophylactic mastectomy to discuss breast reconstruction options.

3 14. Patient A, accompanied by her husband, presented to Respondent on January 12,
4 2015. Respondent discussed with Patient A the option of a skin reducing breast reconstruction
5 and a nipple-sparing breast reconstruction. During that consultation, Respondent informed
6 Patient A that he used Seri Surgical Scaffold² for soft tissue support.

7 15. According to the patient and her husband, Respondent did not discuss the following:
8 (1) the risks/benefits relating to options other than Seri Surgical Scaffold; (2) whether the Seri
9 Surgical Scaffold for breast reconstruction had FDA approval, and (3) that Respondent had
10 participated in Seri Surgical Scaffold studies sponsored by Allergan, the maker of Seri Surgical
11 Scaffold.

12 16. Respondent's medical records, created on or about January 12, 2015, did not reflect
13 that Respondent discussed with the patient alternative options to Seri Surgical Scaffold.

14 17. Respondent performed Patient A's breast reconstruction surgery on February 24,
15 2015. Seri Surgical Scaffold was used in the procedure.

16 18. On May 13, 2015, Patient A underwent second stage breast reconstruction, at which
17 time tissue expanders were removed and implants were placed. Respondent observed that some
18 of the Seri Surgical Scaffold had not been incorporated into the patients' tissue, and Respondent
19 debrided that material.

20 19. In approximately October 2016, in preparation for responding to a Board inquiry
21 about his care of Patient A, Respondent added a notation to Patient A's chart indicating that he
22 had discussed with Patient A the options of Seri Surgical Scaffold as opposed to Alloderm, a
23 collagen scaffold made from cadaver tissue. Respondent did not date or initial this note.
24 Respondent produced these records to the Board in response to a subpoena.

25 20. On or about March 5, 2018, the Board was advised of Respondent's October 2016
26 revision to his January 12, 2015 notes in the patient's medical record.

27
28 ² Seri Surgical Scaffold is a silk netting used in plastic surgery. It serves as a base for the
body to regenerate tissue after medical procedures.

1 21. The standard of care requires that medical records reflect a complete, accurate and
2 contemporaneous account of patient encounters. If errors or omissions are discovered in the
3 medical record, corrections can be made, or additional information added. However, the
4 corrections and/or addenda must be signed and dated to reflect that the "late entry" was made
5 after the date of the patient encounter.

6 22. Respondent made alterations to Patient A's medical record approximately one year
7 and nine months after the relevant patient encounter. His failure to sign and date the entry
8 constitutes a departure from the standard of care.

9 **Patient B**

10 23. Patient B, a 59-year-old female, presented at Respondent's office on May 11, 2016,
11 for a body contouring consultation. She was seen by a physician assistant and referred to
12 Respondent for further consultation.

13 24. On June 14, 2016, Respondent evaluated Patient B and found that she was not a good
14 candidate for body contouring. He recommended abdominoplasty (tummy tuck) and liposuction
15 to the flanks.

16 25. Respondent saw Patient B for a preoperative visit on July 28, 2016, and surgery was
17 scheduled for August 8, 2016, at the Arcadia Outpatient Surgery Center.

18 26. Respondent performed abdominoplasty with liposuction to the flanks on August 8,
19 2016. A bupivacaine pain pump catheter was placed for post-operative pain relief. Norco, an
20 opioid pain medication, was also provided post-surgery.

21 27. Patient B experienced nausea and vomiting when she arrived home after surgery.
22 Upon contacting Respondent's office and leaving a message, she was advised to pick up a nausea
23 medication from the pharmacy. Patient B still did not feel better and decided to stop taking her
24 post-operative pain medications.

25 28. On August 13, 2018, Patient B's husband returned from taking his daughter to dance
26 practice and discovered that Patient B was unresponsive. She was unable to be revived and
27 expired. According to the autopsy report, the cause of death was community-acquired pneumonia
28 with recent elective abdominoplasty as a contributing factor, possibly due to increased pain, and

1 failure to inspire and expand the lungs.

2 29. The medical records for Patient B's visits of May 11, 2016, June 14, 2016, and July
3 28, 2016, were created by multiple authors without a clear indication of who wrote each note.

4 30. Respondent's medical records do not document post-surgical contacts with Patient B
5 or her husband.

6 31. Respondent created personal notes after Patient B's death, which purport to document
7 post-surgical contacts with Patient B and her husband. These personal notes were not included as
8 part of Patient B's medical records. These personal notes include the following information:

9 A. On August 9, 2016, Respondent's patient coordinator called the patient to
10 follow up after surgery and left a message. No call-back from the patient was received.

11 B. On August 11, 2016, a family member contacted Respondent's office stating
12 that the patient suffered from nausea and was unable to "keep anything down." There were no
13 complaints of chest pain, shortness of breath, or excessive abdominal pain. The note reflected
14 that the message was conveyed to Respondent who requested that staff inquire as to whether the
15 symptoms were related to pain medication or antibiotic administration. Staff called the patient's
16 husband and clarified that the patient's symptoms were not related to taking other medications,
17 and Respondent called in a prescription for Zofran, a medication used to prevent nausea and
18 vomiting.

19 32. According to Respondent, Patient B was advised to transition to ibuprofen to manage
20 her pain; however, Patient B's medical record does not reflect this recommendation.

21 33. Respondent failed to document post-surgery communications with Patient B and her
22 family in Patient B's medical records and/or failed to clearly delineate the author of each note.
23 These documentation failures constitute a departure from the standard of care.

24 **Patient C**

25 34. Patient C, a 37-year-old female, presented at Respondent's office in 2013 for bilateral
26 breast reconstruction after planned prophylactic mastectomy. At the initial consultation, Patient
27 C was noted to have asymmetric breasts that were ptotic.

28 35. On January 21, 2014, Patient C had a preoperative visit, documented by Respondent's

1 physician's assistant, during which the risk and benefits of the procedure were discussed. Patient
2 C signed a consent form on that date for "Bilateral Reconstruction with Tissue Expanders." The
3 patient signed a second consent dated January 30, 2014, authorizing a "Bilateral Breast
4 Reconstruction with Tissue Expanders and Seri Scaffold."

5 36. On February 4, 2014, Patient C underwent bilateral mastectomy performed by
6 another physician. Respondent performed the breast reconstruction using Seri Surgical Scaffold
7 to maintain the position of the inframammary fold, and attached it to the lower border of the
8 pectoral muscle and chest wall to maintain the position of the tissue expander,

9 37. Post-operatively, Patient C was noted to have ecchymosis/vascular compromise of the
10 right infero-medial mastectomy flap. On February 19 and March 3, 2014, she returned for
11 debridement of the compromised right breast skin, and reclosure. Subsequently, turbid drainage
12 was noted, and the right tissue expander and the Seri Surgical Scaffold was removed. These
13 procedures were performed at Arcadia Outpatient Surgery Center. At the time of these
14 procedures (as well as subsequent procedures), Respondent had an ownership interest in Arcadia
15 Outpatient Surgery Center, but failed to disclose his ownership interest to Patient C.

16 38. On July 22, 2014, Patient C underwent delayed placement of a right breast tissue
17 expander. On December 30, 2014, she underwent bilateral exchange of her tissue expanders for
18 permanent silicone gel breast implants, and bilateral fat transfer to improve contours.

19 39. Post-operatively, Patient C healed without infection. On January 27, 2015, she was
20 noted to have asymmetry. Patient C also expressed interest in larger implants. On April 7, 2015,
21 Patient C had a preoperative visit, documented by Respondent's physician assistant, who noted
22 that the plan is for "Seri Scaffold in right breast." Patient C signed an informed consent
23 document, dated April 7, 2015, for "Bilateral Breast Implant Replacement Using Silicone Gel
24 Implants and Placement of Strattice vs. Seri Scaffold in Right Breast."

25 40. On April 17, 2015, a second consent form was signed by Patient C for
26 "removal/replacement- bilateral breast implants, placement of alloderm right breast." Patient C
27 had this surgery on that date.

28 41. Subsequently, Respondent performed additional procedures/surgeries on Patient C's

1 breasts, including latissimus dorsi myocutaneous flap plus implant reconstruction of the right
2 breast and reinforcement of the lower-left breast with placement of a larger implant for symmetry.
3 Patient C was last seen by Respondent on February 13, 2017.

4 42. Respondent's failure to disclose to Patient C that he was a paid consultant for
5 Allergan, maker of the Seri Surgical Scaffold at the time, was a departure from the standard of
6 care.

7 43. Respondent's failure to notify Patient C that his use of Seri Surgical Scaffold was an
8 "off label" use was a departure from the standard of care.

9 44. Respondent's failure to accurately document Patient C's diagnosis on surgical
10 scheduling forms and on disability forms (*e.g.*, diagnosis was coded as M53.82 (cervical
11 dorsopathy), which was incorrect) was a departure from the standard of care.

12 45. The consent form signed by Patient C on April 7, 2015 was for placement of
13 "Strattice vs. Seri." The consent form signed at the surgery center was for Alloderm. Alloderm
14 was used in Patient C's surgery. The placement of an incorrect consent form in Patient C's
15 medical record was a departure from the standard of care.

16 46. Respondent's failure to disclose his financial interest in Arcadia Outpatient Surgery
17 Center to Patient C was a departure from the standard of care.

18 47. Respondent committed repeated negligent acts in the care and treatment of Patient A,
19 Patient B, and Patient C, and his license is subject to discipline.

20 **SECOND CAUSE FOR DISCIPLINE**

21 (Failure to Maintain Adequate and Accurate Records)

22 48. Respondent's license is subject to disciplinary action under Code section 2266 in that
23 he failed to maintain adequate and accurate records. The circumstances are as follows:

24 49. The allegations in the First Cause for Discipline are incorporated as if fully set forth.

25 **THIRD CAUSE FOR DISCIPLINE**

26 (Failure to Disclose Financial Interest)

27 50. Respondent's license is subject to disciplinary action under Code section 654.2 and
28 California Code of Regulations, title 16, section 1364.11, subdivision (10), in that he failed to

1 disclose his financial interest in Arcadia Outpatient Surgery Center to Patient C. The
2 circumstances are as follows:

3 51. The allegations in the First Cause for Discipline are incorporated as if fully set forth.

4 52. Respondent had a "significant beneficial interest," as defined by subdivision (d) of
5 Code section 654.2, in Arcadia Outpatient Surgery Center. Respondent failed to disclose this
6 financial interest to Patient C.

7 **PRAYER**

8 **WHEREFORE**, Complainant requests that a hearing be held on the matters herein alleged,
9 and that following the hearing, the Medical Board of California issue a decision:

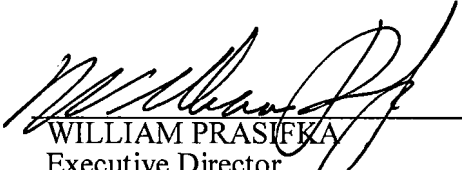
10 1. Revoking or suspending Physician's and Surgeon's Certificate Number A 80511,
11 issued to Max Rudolph Lehfeltdt, M.D.;

12 2. Revoking, suspending or denying approval of Max Rudolph Lehfeltdt, M.D.'s
13 authority to supervise physician assistants and advanced practice nurses;

14 3. If placed on probation, ordering Max Rudolph Lehfeltdt, M.D. to pay the Board the
15 costs of probation monitoring; and

16 4. Taking such other and further action as deemed necessary and proper.

17
18 DATED: **FEB 18 2021**

19 
20 WILLIAM PRASIFKA
21 Executive Director
22 Medical Board of California
23 Department of Consumer Affairs
24 State of California

25 *Complainant*

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28 LA2019501987